

Healthcare Information

Name		
Spouse/Caregiver		
Address		
Contact Information		
Date of Birth		
Social Security #		
Medicare #		
Medicaid #		
Pharmacy Names & Contact Info.		
Supplementary/Secondary Insurance	Name of Company:	Policy #:
	Address:	
	Agent's Name:	Telephone #:
	Premium Account:	Due Date:
	Deductibles:	
Supplementary/Secondary Insurance	Name of Company:	Policy #:
	Address:	
	Agent's Name	Telephone #:
	Premium Account:	Due Date:
	Deductibles:	

Healthcare Decisions

Taking Stock of what you know: (Check one box)

☐ Yes ☐ Wants life Sustaining procedures.

☐ No ☐ Does not want life sustaining procedures.

☐ Uncertain ☐ Has not made a decision

Current Status of documentation about health care decisions:

☐ Yes ☐ No Directive to Physician has been completed.

Location of Original:

Copies given to:

☐ Yes ☐ No The Power of Attorney for health care has been completed.

Location of Original:

Copies given to:

☐ Yes ☐ No Obtained physician order for "Do Not Resuscitate"

Location of Original:

Copies given to:

Location of Other Vital Records

Birth Certificate

Marriage Certificate

Life Insurance Policy

Health Insurance Policy

Funeral Plan and/or Insurance
Policy

Will

Deed to House

Mortgage Papers

Tax Records

Auto Insurance Policy

Contact Information

Clergy		
Name:		Position:
Address:		
Home Phone:	Work Phone:	Cell Phone:
Hospital of Choice		
Name:		
Address:		Phone:
Skilled Nursing/Rehabilitation Center of Choice		
Name:		
Address:		Phone:
Home Health Agency of Choice		
Name:		
Address:		Phone:
Hospice Provider of Choice		
Name:		
Address:		Phone:
Other Providers		
Name:		
Address:		Phone:

Emergency Contacts

Name:	
Address:	
Relationship:	Home Phone:
Cell Phone:	Work Phone:
Name:	
Address:	
Relationship:	Home Phone:
Cell Phone:	Work Phone:
Name:	
Address:	
Relationship:	Home Phone:
Cell Phone:	Work Phone:
Name:	
Address:	
Relationship:	Home Phone:
Cell Phone:	Work Phone:

Family History/Personal Habitats/Allergies

Family History <i>Do or have any siblings, parents, grandparents have/had a history of:</i>		
___Diabetes	___Depression	___Asthma/COPD
___High Blood Pressure	___Alcohol Abuse	___Dementia
___Heart Disease (Before age 60)	___Cancer (Type_____)	___Other (_____)
Personal Habits		
___Currently Smokes Cigars___ Pipe___ Cigarettes___ ___Per day, for ___years.		
___Stopped Smoking ___(approx.. year)		
___Drinks Alcohol ___drinks per day		
___Exercises ___Minutes ___days per week.		
Allergies		
Cause	Reaction & Treatment	

Health History

Medical Condition/Diagnosis	Date Diagnosed	Physician Treating Condition

Procedures/Surgeries	Date Diagnosed	Physician Performed Procedure

Health Exams & Screenings/Immunizations

	Date/Results	Date/Results	Date/Results	Date/Results	Date/Results
Blood Pressure					
Cholesterol or Lipid Panel					
Blood Sugar					
Eye Exam/Glaucoma					
Dental					
Hearing					
Fecal Occult Blood					
Colorectal Screening					
Mammogram					
Clinical Breast Exam					
Pap Test					
Bone Density					
Other: _____					

Check with the doctor for specific recommendations on frequency of health exams and screenings based on age, health, and medical history.

Vaccine	Date				
Influenza (After age 50)					
Pneumonia (After age 65)					
Tetanus/Diphtheria (Every 10 years)					
Hepatitis B (Per risk status)					
Tuberculosis (Per risk status)					
Other					

Medical Visit Tracker

[illegible]

Medical Visit Tracker

[illegible]

Medical Visit Tracker

[illegible]

Physicians/Other Health Workers

Name:	
Specialty:	
Address:	
Phone: Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Name:	
Specialty:	
Address:	
Phone: Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Physicians/Other Health Workers

Name:	
Specialty:	
Address:	
Phone: Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Name:	
Specialty:	
Address:	
Phone: Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Physicians/Other Health Workers

Name:	
Specialty:	
Address:	
Phone: Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Name:	
Specialty:	
Address:	
Phone: Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Physicians/Other Health Workers

Name:	
Specialty:	
Address:	
Phone:	
Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Name:	
Specialty:	
Address:	
Phone:	
Fax:	
Seen for these Medical Conditions:	
Last Appt.	Next Appt.
Notes:	

Symptom Reporting Form

Prepared for medical appointment with: _____ Date: _____

Diet:

Is he/she eating well? Is there a sudden change in diet or eating patterns? Is weight stable?

- | | | |
|---|---|--|
| <input type="checkbox"/> Extreme Thirst | <input type="checkbox"/> Lack of Thirst | <input type="checkbox"/> un-explained weight loss/gain |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Pain before/after eating | <input type="checkbox"/> Difficulty chewing food |
| <input type="checkbox"/> Pain in gums/teeth | <input type="checkbox"/> Cough when eating/drinking | <input type="checkbox"/> Recurring gum infection |

Sleep and Activity Patterns

Is he/she sleeping well?

- | | | |
|--|---|---|
| <input type="checkbox"/> Unable to fall asleep | <input type="checkbox"/> Wakes up and unable to go to sleep | <input type="checkbox"/> Has nightmares |
| <input type="checkbox"/> Sleeps restlessly | <input type="checkbox"/> Unusual tiredness or drowsiness | |

Does the patient seem to have "slowed down" noticeably since last Dr. visit? If so, in what way?

- | | | |
|---|--|--|
| <input type="checkbox"/> Falls: if so, how often? | <input type="checkbox"/> Leg pain when walking | <input type="checkbox"/> Painful or limited movement |
| <input type="checkbox"/> Inability to move | <input type="checkbox"/> Tires easily, shortness of breath | <input type="checkbox"/> Limbs moving as they usually do |

Bowel/Bladder/Abdomen

Are his urinary and digestive systems working well?

- | | | | |
|--|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bowel movements of and odd color, texture, amount | <input type="checkbox"/> draining sores or pain from penis | | |
| <input type="checkbox"/> Vaginal discharge (report color, odor, amount) | <input type="checkbox"/> Pain in the kidney area | | |
| <input type="checkbox"/> Pain on urination (unusual color, amount, odor) | <input type="checkbox"/> Frequent urination | | |
| <input type="checkbox"/> Frequent bladder infections | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Vomiting |

Bones, Muscles, Joints, & Skin

- | | | |
|---|---|--|
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Twitching or involuntary movement | <input type="checkbox"/> Tingling or numbness |
| <input type="checkbox"/> Warm, tender joints | <input type="checkbox"/> redness in joints | <input type="checkbox"/> Unusual position of limbs |
| <input type="checkbox"/> Changes in color of lips, nails, fingers, and toes | <input type="checkbox"/> Change in shape/color of mole | |
| <input type="checkbox"/> Unusual appearance of surgery incision | <input type="checkbox"/> Pressure sores (bed sores) | |
| <input type="checkbox"/> Unusual skin color, temperature, texture, bruises | <input type="checkbox"/> Sudden skin rashes (bumps/itching) | |

Chest/Heart

- | | | |
|---|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Rapid pulses | <input type="checkbox"/> Painful breathing (wheezing/SOB) |
| <input type="checkbox"/> Problems with breasts (lumps, discharge, soreness) | <input type="checkbox"/> Unusual cough | |
| <input type="checkbox"/> Unusual sputum (report color/consistency) | | |
| <input type="checkbox"/> Quality of breathing (rapid, shallow, gasping, rattling) | | |

Head

- | | |
|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Ear pain (discharge, change in hearing) | <input type="checkbox"/> Eye pain (discharge, redness, sensitivity, blurry) |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Nose pain (bleeding, unpleasant odor of discharge) |

Symptom Reporting Form

Medications

- ___ Taking on time ___ at prescribed dosage ___ Complaints or suffering from side effects
- ___ Any sudden change in response to any medication, if so in what way _____
- ___ Did stop taking any medication(s), if so for what reason _____
- ___ New medications Rx by different physician (i.e. specialist)

Emotional and Mental Well-being

- ___ Unusual actions (aggression, anger, withdrawal) ___ Hallucinations ___ Anxiety
- ___ Increased confusion ___ Depression ___ Noticeable decrease in mental function
- ___ Change in long or short-term memory ___ Fearful ___ Sad ___ Excitable

Pain

Is he/she complaining about pain?

What does it feel like?

- ___ Sharp ___ Stabbing ___ Dull ___ Pounding ___ Achy ___ Tingling
- ___ Other _____

Where is it located?

- ___ All over ___ Head ___ Abdomen ___ Limbs ___ Other specific location

On a scale of 1-10, how does he/she rate the pain.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

How long has the pain lasted? _____

Does it move around or stay in one place?

Does the pain seem to occur in relation to something else?
(e.g. eating, standing up suddenly, reaching)

Is there anything that makes the pain better or worse?

Does pain medication help? If so, how much?

Symptom Reporting Form

Prepared for medical appointment with: _____ Date: _____

Diet:

Is he/she eating well? Is there a sudden change in diet or eating patterns? Is weight stable?

☐ Extreme Thirst ☐ Lack of Thirst ☐ un-explained weight loss/gain
☐ Loss of Appetite ☐ Pain before/after eating ☐ Difficulty chewing food
☐ Pain in gums/teeth ☐ Cough when eating/drinking ☐ Recurring gum infection

Sleep and Activity Patterns

Is he/she sleeping well?

☐ Unable to fall asleep ☐ Wakes up and unable to go to sleep
☐ Has nightmares ☐ Sleeps restlessly ☐ Unusual tiredness or drowsiness

Does the patient seem to have “slowed down” noticeably since last Dr. visit? If so, in what way?

☐ Falls: if so, how often? ☐ Leg pain when walking ☐ Painful or limited movement
☐ Inability to move ☐ Tires easily, shortness of breath ☐ Limbs moving as they usually do

Bowel/Bladder/Abdomen

Are his urinary and digestive systems working well?

☐ Heartburn ☐ Excessive Gas ☐ Diarrhea ☐ Constipation
☐ Bowel movements of and odd color, texture, amount ☐ draining sores or pain from penis
☐ Vaginal discharge (report color, odor, amount) ☐ Pain in the kidney area
☐ Pain on urination (unusual color, amount, odor) ☐ Frequent urination
☐ Frequent bladder infections ☐ Blood in urine ☐ Stomach pain
☐ Vomiting

Bones, Muscles, Joints, & Skin

☐ Swelling ☐ Twitching or involuntary movement ☐ Tingling or numbness
☐ Warm, tender joints ☐ redness in joints ☐ Unusual position of limbs
☐ Changes in color of lips, nails, fingers, and toes ☐ Change in shape/color of mole
☐ Unusual appearance of surgery incision ☐ Pressure sores (bed sores)
☐ Unusual skin color, temperature, texture, bruises
☐ Sudden skin rashes (bumps/itching)

Chest/Heart

☐ Chest pain ☐ Rapid pulses ☐ Painful breathing (wheezing/SOB)
☐ Problems with breasts (lumps, discharge, soreness) ☐ Unusual cough
☐ Unusual sputum (report color/consistency) ☐ Quality of breathing (rapid, shallow, gasping, rattling)

Head

☐ Dizziness ☐ Headaches ☐ Ear pain (discharge, change in hearing)
☐ Eye pain (discharge, redness, sensitivity, blurry) ☐ Mouth sores
☐ Nose pain (bleeding, unpleasant odor of discharge)

Symptom Reporting Form

Medications

___ Taking on time ___ at prescribed dosage ___ Complaints or suffering from side effects
___ Any sudden change in response to any medication, if so in what way _____
___ Did stop taking any medication(s), if so for what reason _____
___ New medications Rx by different physician (i.e. specialist)

Emotional and Mental Well-being

___ Unusual actions (aggression, anger, withdrawal) ___ Hallucinations ___ Anxiety
___ Increased confusion ___ Depression ___ Noticeable decrease in mental function
___ Change in long or short-term memory ___ Fearful ___ Sad ___ Excitable

Pain

Is he/she complaining about pain?

What does it feel like?

___ Sharp ___ Stabbing ___ Dull ___ Pounding ___ Achy ___ Tingling
___ Other _____

Where is it located?

___ All over ___ Head ___ Abdomen ___ Limbs ___ Other specific location

On a scale of 1-10, how does he/she rate the pain.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

How long has the pain lasted? _____

Does it move around or stay in one place?

Does the pain seem to occur in relation to something else?
(e.g. eating, standing up suddenly, reaching)

Is there anything that makes the pain better or worse?

Does pain medication help? If so, how much?

Symptom Reporting Form

Prepared for medical appointment with: _____ Date: _____

Diet:

Is he/she eating well? Is there a sudden change in diet or eating patterns? Is weight stable?

☐ Extreme Thirst ☐ Lack of Thirst ☐ un-explained weight loss/gain
☐ Loss of Appetite ☐ Pain before/after eating ☐ Difficulty chewing food
☐ Pain in gums/teeth ☐ Cough when eating/drinking ☐ Recurring gum infection

Sleep and Activity Patterns

Is he/she sleeping well?

☐ Unable to fall asleep ☐ Wakes up and unable to go to sleep
☐ Has nightmares ☐ Sleeps restlessly ☐ Unusual tiredness or drowsiness

Does the patient seem to have "slowed down" noticeably since last Dr. visit? If so, in what way?

☐ Falls: if so, how often? ☐ Leg pain when walking ☐ Painful or limited movement
☐ Inability to move ☐ Tires easily, shortness of breath ☐ Limbs moving as they usually do

Bowel/Bladder/Abdomen

Are his urinary and digestive systems working well?

☐ Heartburn ☐ Excessive Gas ☐ Diarrhea ☐ Constipation
☐ Bowel movements of and odd color, texture, amount ☐ draining sores or pain from penis
☐ Vaginal discharge (report color, odor, amount) ☐ Pain in the kidney area
☐ Pain on urination (unusual color, amount, odor) ☐ Frequent urination
☐ Frequent bladder infections ☐ Blood in urine ☐ Stomach pain
☐ Vomiting

Bones, Muscles, Joints, & Skin

☐ Swelling ☐ Twitching or involuntary movement ☐ Tingling or numbness
☐ Warm, tender joints ☐ redness in joints ☐ Unusual position of limbs
☐ Changes in color of lips, nails, fingers, and toes ☐ Change in shape/color of mole
☐ Unusual appearance of surgery incision ☐ Pressure sores (bed sores)
☐ Unusual skin color, temperature, texture, bruises
☐ Sudden skin rashes (bumps/itching)

Chest/Heart

☐ Chest pain ☐ Rapid pulses ☐ Painful breathing (wheezing/SOB)
☐ Problems with breasts (lumps, discharge, soreness) ☐ Unusual cough
☐ Unusual sputum (report color/consistency) ☐ Quality of breathing (rapid, shallow, gasping, rattling)

Head

☐ Dizziness ☐ Headaches ☐ Ear pain (discharge, change in hearing)
☐ Eye pain (discharge, redness, sensitivity, blurry) ☐ Mouth sores
☐ Nose pain (bleeding, unpleasant odor of discharge)

Symptom Reporting Form

Medications

___ Taking on time ___ at prescribed dosage ___ Complaints or suffering from side effects
___ Any sudden change in response to any medication, if so in what way _____
___ Did stop taking any medication(s), if so for what reason _____
___ New medications Rx by different physician (i.e. specialist)

Emotional and Mental Well-being

___ Unusual actions (aggression, anger, withdrawal) ___ Hallucinations ___ Anxiety
___ Increased confusion ___ Depression ___ Noticeable decrease in mental function
___ Change in long or short-term memory ___ Fearful ___ Sad ___ Excitable

Pain

Is he/she complaining about pain?

What does it feel like?

___ Sharp ___ Stabbing ___ Dull ___ Pounding ___ Achy ___ Tingling
___ Other _____

Where is it located?

___ All over ___ Head ___ Abdomen ___ Limbs ___ Other specific location

On a scale of 1-10, how does he/she rate the pain.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

How long has the pain lasted? _____

Does it move around or stay in one place?

Does the pain seem to occur in relation to something else?

(e.g. eating, standing up suddenly, reaching)

Is there anything that makes the pain better or worse?

Does pain medication help? If so, how much?

Symptom Reporting Form

Medications

___ Taking on time ___ at prescribed dosage ___ Complaints or suffering from side effects
___ Any sudden change in response to any medication, if so in what way _____
___ Did stop taking any medication(s), if so for what reason _____
___ New medications Rx by different physician (i.e. specialist)

Emotional and Mental Well-being

___ Unusual actions (aggression, anger, withdrawal) ___ Hallucinations ___ Anxiety
___ Increased confusion ___ Depression ___ Noticeable decrease in mental function
___ Change in long or short-term memory ___ Fearful ___ Sad ___ Excitable

Pain

Is he/she complaining about pain?

What does it feel like?

___ Sharp ___ Stabbing ___ Dull ___ Pounding ___ Achy ___ Tingling
___ Other _____

Where is it located?

___ All over ___ Head ___ Abdomen ___ Limbs ___ Other specific location

On a scale of 1-10, how does he/she rate the pain.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

How long has the pain lasted? _____

Does it move around or stay in one place?

Does the pain seem to occur in relation to something else?
(e.g. eating, standing up suddenly, reaching)

Is there anything that makes the pain better or worse?

Does pain medication help? If so, how much?

Doctor Appointment Worksheet

Name of Physician	Date and Time of Visit
Purpose of visit:	
Questions to ask at appointment	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date;	
Changes in medication	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Procedures, Tests, Surgeries	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	

Doctor Appointment Worksheet

General Notes

Doctor Appointment Worksheet

Name of Physician	Date and Time of Visit
Purpose of visit:	
Questions to ask at appointment	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date;	
Changes in medication	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Procedures, Tests, Surgeries	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	

Doctor Appointment Worksheet

General Notes

Doctor Appointment Worksheet

Name of Physician	Date and Time of Visit
Purpose of visit:	
Questions to ask at appointment	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date;	
Changes in medication	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Procedures, Tests, Surgeries	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	

Doctor Appointment Worksheet

General Notes

Doctor Appointment Worksheet

Name of Physician	Date and Time of Visit
Purpose of visit:	
Questions to ask at appointment	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date:	
Who and what to ask:	
Response/date;	
Changes in medication	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Name of medication _____ dosage _____ frequency _____ new _____ change _____	
Procedures, Tests, Surgeries	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	
Type/Name _____ Date scheduled/completed _____	
F/u needed	
Date and results:	

Doctor Appointment Worksheet

General Notes

Medications

Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency

Medications

Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency

Medications

Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency

Medications

Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency
Drug/brand/generic name	Refill #
Prescribing Doctor	Pharmacy
Reason taking drug	Dosage
Possible side effect	Frequency

Care Notes

Date	Time	Notes

Care Notes

Date	Time	Notes

Care Notes

Date	Time	Notes

Identify Self Care Abilities

Self Care Abilities and Needs Checklist

Name: _____

Date: Completed: _____ Completed by: _____

Activities of Daily Living: Focuses on the most basic activities of daily living, or ADL's, measuring the person in your care's ability to perform them without assistance. Check the level of assistance needed for each of the following activities.

Bathing

- ☐ No assistance needed
- ☐ Can bathe, but is often dirty
- ☐ Some help needed
- ☐ Lacks strength or agility to bathe safely

Dressing/Grooming

- ☐ No assistance needed
- ☐ May need help with certain things, such as buttons or shoes
- ☐ Can dress if someone selects clothes
- ☐ Can dress, but isn't concerned about clothes or appearance
- ☐ Needs help dressing and undressing

Eating/Feeding

- ☐ No assistance needed
- ☐ Needs some assistance
- ☐ Forgets to eat or eats at odd times
- ☐ Can feed self, but need help with certain foods or a specific diet
- ☐ Swallowing problems, food must be pureed
- ☐ Must be fed

Walking/Transferring

- ☐ No assistance is needed
- ☐ Needs walker/cane for balance or support
- ☐ Needs to hold onto someone or something
- ☐ Needs cane, walker, wheelchair
- ☐ Can move around; but waits for assistance
- ☐ Needs help getting in or out of chairs
- ☐ Needs help getting in or out of bed
- ☐ Essentially bedridden

Toileting

- ☐ No assistance is needed
- ☐ Needs assistance getting on or off toilet
- ☐ Needs assistance getting clothes off or on
- ☐ Forgets what the toilet is for

- ☐ Needs bedpan or portable toilet at night
- ☐ Needs bedpan or portable toilet day and night

Continence

- ☐ Full control of bladder
- ☐ Full control of bowels
- ☐ Occasional bowel accidents
- ☐ Occasional bladder accidents
- ☐ Accidents caused by decreased mental capacity
- ☐ Regular problems, needs protective pads/briefs

Instrumental Activities of Daily Living cover what are considered a person's ability to complete tasks that require simple planning, reasoning, and judgment. Try to determine if the person would be able to perform the task.

Housework/Laundry

- ☐ Knows what needs to be done and is able to do it independently
- ☐ Able to do it, but only if prompted
- ☐ Needs some help
- ☐ Unable to do it; even if prompted

Meal Preparation

- ☐ Can plan and prepare meals
- ☐ Can plan and prepare only simple meals
- ☐ Cannot plan, but can prepare a simple meal if assisted
- ☐ Cannot plan or prepare even a simple meal

Transportation

- ☐ Can travel independently using private or public transportation
- ☐ Can plan travel; but needs assistance
- ☐ Depends on others for all transportation needs

Shopping

- ☐ Independent
- ☐ Needs transportation; independent once there
- ☐ Needs some assistance
- ☐ Unable to do, depends entirely on others

Identify Self Care Abilities

Money Management

- ☐ Able to manage finances and pay bills
- ☐ Requires some assistance to manage finances
- ☐ Unable to manage finances or pay bills

Medication Management

- ☐ Remembers to take medicine according to directions
- ☐ Remembers to take medicine but needs assistance in set up
- ☐ Will take according to directions if reminded
- ☐ Cannot be trusted to take medicine properly, even if reminded
- ☐ Relies on someone else to set up and administer

Telephone

- ☐ Can use the telephone and find a number
- ☐ Can use the telephone if number is known
- ☐ Cannot use the telephone

Other Care Needs that should be considered as you look at how to best plan for person being cared for.

Vision

- ☐ Normal/minimal loss
- ☐ Moderate loss (cannot read newsprint)
- ☐ Severe loss/blind

Hearing

- ☐ Normal/minimal loss
- ☐ Moderate loss (can hear in quiet setting)
- ☐ Severe loss/deaf

Communication

- ☐ Always able to express needs
- ☐ Usually able to express needs (i.e. has difficulty finding words, remembering certain things)
- ☐ Unable to express needs

Emotional State

- ☐ Agitation/aggressiveness
If yes, ☐ Sometimes ☐ Always
- ☐ Depression
If yes, ☐ Sometimes ☐ Always
- ☐ Anxiety
If yes, ☐ Sometimes ☐ Always
- ☐ Suspiciousness/Hostility
If yes, ☐ Sometimes ☐ Always
- ☐ Sleep problems
If yes, ☐ Sometimes ☐ Always

Cognitive Patterns

- ☐ Short-term memory problems (usually unable to recall after five minutes)
- ☐ Procedural memory problems (unable to perform all or almost all steps in a multitask sequence without cues)
- ☐ Decisions consistent/reasonable/safe
- ☐ In specific situations, decisions become poor or unsafe, cues/supervision needed at those times
- ☐ Decision consistently poor or unsafe

Safety Concerns

- ☐ Wandering
If yes, ☐ Sometimes (note trigger and response)
☐ Always
- ☐ Protective devices and/or safety equipment needed
 - ☐ Emergency Response System
 - ☐ Door/window alarms
 - ☐ Bathroom safety equipment
 - ☐ Bedrails
 - ☐ Medical alert bracelet, Safe Return
 - ☐ Safety locks on cabinets, doors, stove
- ☐ Unable to use stove and/or fireplace safely
- ☐ Environmental Concerns
 - ☐ Home repairs needed
 - ☐ Throw rugs
 - ☐ Access to/from the home
 - ☐ Entrances and walkways clear
 - ☐ Hallways and doorways clear
 - ☐ Difficulty entering/leaving home

Social Activities

- ☐ Actively involved in social activities
- ☐ Decrease in ability to participate in social activities
- ☐ Socially isolation self
- ☐ Unable to participate in social activities

Note any Triggering responses that may cause behavior:

Daily Activities Schedule

Bathing and Personal Care Needs

Outside Provider ___yes ___no Name and Number:

Days per week: Mon Tue Wed. Thus Fri Sat Sun Time: _____am/pm

Type: ___Bed ___Tub ___Tub w/ shower chair ___Shower ___Other_____

Hair Care: Wash on ___Mon ___Tue ___Wed ___Thurs ___Fri ___Sat ___Sun

Hair done at beauty salon on _____

Oral Care: ___Brush ___Floss ___Dentures

Note any special oral care needs:

Skin Care: ___Lotion upper body ___Lotion lower body ___Powdered

Note any special creams or lotions:

Toileting/Continence Care:

Continence supplies: ___Pads ___Pull-ups ___Wipes

Note any other pertinent information regarding bathing/personal care needs:

Mobility Limitations

Walks Alone_____ Stands

Alone_____

Equipment used: ___Walker ___Cane ___Wheelchair ___Brace ___Other_____

Help in transferring to/from: ___Chair ___Bed ___Toilet

Equipment used: ___Lift chair ___Walker ___Grab bars ___Trapeze

Activities/Exercise ___Yes ___No Where/How/When

Walk _____

TV _____

Reading _____

Listening to Music _____

Visitor's _____

Calls to Friends/Relatives _____

Other _____

Daily Activities Schedule

<u>Medical Care/Treatments</u>			
Treatments:	Yes	No	Who/When/How
Catheter	_____	_____	_____
Oxygen	_____	_____	_____
Physical Therapy	_____	_____	_____
Nursing Care	_____	_____	_____
Equipment	_____	_____	_____
	Yes	No	When used/Where located
Hearing Aides	_____	_____	_____
Eye Glasses	_____	_____	_____
<u>Meals & Nutrition</u>			
Meal Schedule			
_____ am Breakfast, usual _____			
_____ am/pm Lunch, usual _____			
_____ pm Dinner, usual _____			
_____ am _____ pm Snacks, usual _____			
Help needed with meals _____			
Special Diets _____			
Favorite Foods _____			
Foods to avoid _____			
Special Utensils _____			
Location of Meals _____			

Daily Activities Schedule

Bedtime/Nighttime Routine			
	Yes	No	Where/How
Help needed undressing	___	___	_____
Denture Care	___	___	_____
Incontinence Pad/Briefs	___	___	_____
Medication	___	___	_____
Special Pillow/Blanket	___	___	_____
Music/Radio/TV	___	___	_____
Nightlight	___	___	_____
Urinal/Bedpan	___	___	_____
Safety gates at doors/on Stairs	___	___	_____
Calming Techniques	___	___	_____
Special Care Needs			
Wandering_____			
Behaviour Problems_____			

Stressors_____			
Soothers_____			
Other_____			

Special Problems 1. 2. 3. 4. 5.	Have Tried 1. 2. 3. 4. 5.	Works Best 1. 2. 3. 4. 5.	

Daily Routine

Form for recording a typical schedule of activities for the person you are caring for. Providers and back-up caregivers can use this to understand what the person's routine and help to reduce disruption in care that may cause anxiety and/or behavioral problems.

[illegible]

Developing Plan of Care

Care Need	Is help needed?	Frequency	Name of current helper	Is additional help needed?
Bathing Assistive devices needed	___ Yes ___ No			
Dressing/Grooming	___ Yes ___ No			
Eating/Feeding Assistive devices needed	___ Yes ___ No			
Walking/Transferring Assistive devices needed	___ Yes ___ No			
Toileting Assistive Devices needed	___ Yes ___ No			
Continence Needs incontinence supplies	___ Yes ___ No			
Housework/Laundry	___ Yes ___ No			
Meal Preparation Meals on Wheels Congregate meals Liquid supplemental	___ Yes ___ No			
Medication Management	___ Yes ___ No			
Money Management	___ Yes ___ No			
Transportation	___ Yes ___ No			
Shopping	___ Yes ___ No			
Telephone Assistive devices needed	___ Yes ___ No			
Vision Assistive devices needed	___ Yes ___ No			
Hearing Assistive devices needed	___ Yes ___ No			
Safety devices/equipment ERS system Safe Return Med Alert Bracelet Door/Window alarms Other equipment	___ Yes ___ No ___ Yes ___ No ___ Yes ___ No ___ Yes ___ No ___ Yes ___ No ___ Yes ___ No			
Chore Services Home Repair	___ Yes ___ No			
Respite Care for caregiver	___ Yes ___ No			

Weekly Medication Record

Medication Name, dosage, special notes	Time of day	Sun Dose	Mon Dose	Tues Dose	Wed Dose	Thurs Dose	Fri Dose	Sat Dose
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							

Weekly Medication Record

Medication Name, dosage, special notes	Time of day	Sun Dose	Mon Dose	Tues Dose	Wed Dose	Thurs Dose	Fri Dose	Sat Dose
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							

Weekly Medication Record

Medication Name, dosage, special notes	Time of day	Sun Dose	Mon Dose	Tues Dose	Wed Dose	Thurs Dose	Fri Dose	Sat Dose
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							
	Morning:							
	Noon:							
	Night:							
	Other:							

Vital Information Checklist

Name:

- ☐ Current Name
- ☐ Maiden Name
- ☐ Nicknames
- ☐ Previous Married Names

Identification

- ☐ Social Security Card
- ☐ Passport
- ☐ Driver's License
- ☐ Medicare Claim Card
- ☐ Birth Certificate
- ☐ Marriage Certificate
- ☐ VA claim number for honorable discharge certificate
- ☐ Spouse's Death Certificate
- ☐ Spouse's Social Security number
- ☐ Naturalization Papers
- ☐ Adoption Papers
- ☐ Divorce Papers or decree
- ☐ Employer Identification number

Financial Information

- ☐ Checking Accounts
 - ☐ Banks
 - ☐ Credit Unions
 - ☐ Brokerage
 - ☐ Lines of Credit
- ☐ Savings Account
 - ☐ Banks
 - ☐ Credit Unions
- ☐ CD's (Certificate of Deposit) or Savings certificate
- ☐ Savings Bond
- ☐ Money Market Accounts
- ☐ Publicly Traded Bonds and notes
- ☐ Publicly Traded Stock Certificates
- ☐ Mutual Fund Shares
- ☐ IRA's (Individual Retirement Accounts)
- ☐ Keogh-type Plans
- ☐ 401(k) or 403(b) Plans
- ☐ Insurance Policies (with equity or cash value)
- ☐ Income
 - ☐ Social Security
 - ☐ Pension Plans
 - ☐ Annuity Contracts
 - ☐ Trust Funds
 - ☐ Loans/Notes receivable
 - ☐ Government Programs

- ☐ Miscellaneous
- ☐ Real Estate
 - ☐ Primary Residence
 - ☐ Secondary Residence
 - ☐ Other Residences
- ☐ Rental Properties
- ☐ Time Share
- ☐ Undeveloped Land
- ☐ Cemetery Plot
- ☐ Personal Property
 - ☐ Automobiles
 - ☐ Other items requiring ownership documents
- ☐ Special Collections
- ☐ Personal Possessions
- ☐ Insurance
 - ☐ Whole Life
 - ☐ Term Life
 - ☐ Group Life
- ☐ Automobile
- ☐ Homeowners
- ☐ Renters

Vital Information

Vital Information Record for:
Date Completed
Location of Documents
Name on Birth Certificate:
Name of Social Security Card or with Social Security Administration
Maiden Name:
Other Names (previous marriages, other spellings, nicknames):
Identification: Social Security Number: _____ (make copy) Passport Number: _____ (make copy) Driver's License Number: _____ (make copy) Medicare Claim Number: _____ (make copy) Birth Certificate: _____ (have several copies) Marriage Certificate: _____ VA Claim Number: _____ Honorable Discharge Certificate: _____ Death Certificate of Spouse: _____ Social Security Number of Spouse: _____ Naturalization Papers: _____ Adoption Papers: _____ Divorce Papers, settlement agreements, court orders: _____ _____ Employer Identification Number: _____

Account Information

A. Checking Account (type of account ___ Bank ___ Credit Union ___ Brokerage ___ Line of Credit)

Bank _____ Branch _____ Account Number: _____

Authorized signers:

Who manages checkbook?

Where are statements sent?

Direct Deposits:

Direct Withdrawals:

Is there overdraft protection?

How much?

ATM or debit card?

Who has card?

B. Checking Account (type of account ___ Bank ___ Credit Union ___ Brokerage ___ Line of Credit)

Bank _____ Branch _____ Account Number: _____

Authorized signers:

Who manages checkbook?

Where are statements sent?

Direct Deposits:

Direct Withdrawals:

Is there overdraft protection?

How much?

ATM or debit card?

Who has card?

A. Savings Account type of account ___ Bank ___ Credit Union ___ Brokerage ___ Line of Credit

Financial Institution _____ Branch _____ Account Number _____

Authorized signers:

Who manages the account?

Where are the statements sent?

Direct Deposits:

Direct Withdrawals:

B. Savings Account (type of account ___ Bank ___ Credit Union ___ Brokerage ___ Line of Credit)

Financial Institution _____ Branch _____ Account Number _____

Authorized signers:

Who manages the account?

Where are the statements sent?

Direct Deposits:

Direct Withdrawals:

Account Information

CD's (Certificate of Deposit) or savings certificates		
Financial Institution	Branch	Account Number
Amount:	Interest Rate:	Maturity Date:
Who has CD?		Renewal date:
Names (if held in joint):		
Financial Institution	Branch	Account Number
Amount:	Interest Rate:	Maturity Date:
Who has CD?		Renewal date:
Names (if held in joint):		
Financial Institution	Branch	Account Number
Amount:	Interest Rate:	Maturity Date:
Who has CD?		Renewal date:
Names (if held in joint):		
Savings Bond		
Number on Bond:		Face Amount:
Maturity Date:	Who had Bond?	
Names (if held in joint):		
Number on Bond:		Face Amount:
Maturity Date:	Who had Bond?	
Names (if held in joint):		
Money Market Accounts		
Institution or company		
Account Number:		
Contact Person:	Direct Deposit?	
Authorized signers:		
Institution or company		
Account Number:		
Contact Person:	Direct Deposit?	
Authorized signers:		

Account Information

Publicly traded bonds and notes		
A. Issuer:		Face Value:
CUSIP number:	Maturity Rate:	Interest Payment Date:
Coupon or Bond?	Fixed or Variable rate?	
Names (if held in joint):		
B. Issuer:		Face Value:
CUSIP number:	Maturity Rate:	Interest Payment Date:
Coupon or Bond?	Fixed or Variable rate?	
Names (if held in joint):		
Publicly traded stock certificates		
A. Company		
Number of shares:	Who holds the shares?	
Names (if held in joint):		
Date purchased:	Price at acquisition:	
B. Company		
Number of shares:	Who holds the shares?	
Names (if held in joint):		
Date purchased:	Price at acquisition	
C. Company		
Number of shares:	Who holds the shares?	
Names (if held in joint):		
Date purchased:	Price at acquisition	
Mutual Fund Shares		
A. Fund name:		
Number of shares:	Account number:	
Joint name or restrictions:		
Date purchased:	Price at acquisition:	
B. Fund name:		
Number of shares:	Account number:	
Joint name or restrictions:		
Date purchased:	Price at acquisition:	

Income

Social Security	
Eligible for? ___Yes ___No	Applied for? ___Yes ___No
Receiving? ___Yes ___No	
Direct Deposit? ___Yes ___No	Name of Financial Institution:
Pension Plans	
Payer:	Reference Number:
Type of Plan:	Joint/Survivor option:
Payer:	Reference Number:
Type of Plan:	Joint/Survivor option:
Annuity Contracts	
Payer:	Contact person or agent:
Reference Number:	Payment Dates:
Payer:	Contact person or agent:
Reference Number:	Payment Dates:
Trust Funds	
Payer:	Contact person or agent:
Reference Number:	Payment Dates:
Loans/Notes receivable	
Obligor:	Interest Rate:
Security:	Payment Dates:
Location of contract or note:	Due Date:
Obligor:	Interest Rate:
Security:	Payment Dates:
Location of contract or note:	Due Date:

Income

Government Programs (such as worker's compensation)	
Program:	Contact Person:
Type:	Payment Dates:
Program:	Contact Person:
Type:	Payment Dates:
Inheritance	
From:	Payment Date:
Amount:	
From:	Payment Date:
Amount:	
Lottery or contest winnings	
Amount:	Payment Date:
Gift Money	
Gift from:	Payment Date:
Amount:	
Life Insurance Proceeds	
Name of the Deceased:	
Payment Date:	Amount:
Obligor:	Interest Rate:
Security:	Payment Dates:
Location of contact or note:	Due Date:

Real Estate

Primary Residence	
Address: Name(s) on Deed: Deed Location: Who is living there? Manager name, if condo or coop:	Condo or Cooperative? Telephone Number:
Secondary Residence	
Address: Name(s) on Deed: Deed Location: Who is living there? Manager name, if condo or coop:	Condo or Cooperative? Telephone Number:
Other Residence	
Address: Name(s) on Deed: Deed Location: Who is living there? Manager name, if condo or coop:	Condo or Cooperative? Telephone Number:
Rental Property	
Address: Name(s) on Deed: Deed Location: Who is living there? Manager name, if condo or coop:	Condo or Cooperative? Telephone Number:
Time Share:	
Address: Name(s) on time share: Duration:	Use Periods: Management Agent:
Undeveloped Land	
Address: Name(s) on Deed: Current use:	
Cemetery Plot	
Address: Plot Location:	

Personal Property

Automobiles

Year: Make: Model:

Own or Lease? Name on title:

Vehicle Identification Number (VIN):

Lien holder or loss payee:

Year: Make: Model:

Own or Lease? Name on title:

Vehicle Identification Number (VIN):

Lien holder or loss payee:

Other items requiring ownership documents (boat, airplane, trailer, and so forth):

Special Collections (stamp, dolls, gums, coins, jewelry, and so forth):

Item: Owner: Location:

Condition:

Item: Owner: Location:

Condition:

Item: Owner: Location:

Condition:

Item: Owner: Location:

Condition:

Insurance

Life Insurance		
Amount:	Beneficiary:	
Premium due date:	Company:	
Agent:	Policy number:	
Type of insurance:		
Amount:	Beneficiary:	
Premium due date:	Company:	
Agent:	Policy number:	
Type of insurance:		
Amount:	Beneficiary:	
Premium due date:	Company:	
Agent:	Policy number:	
Type of insurance:		
Automobile Insurance		
Company:	Policy number:	
Agent:	Policy Expires:	Deductibles:
Homeowners Insurance		
Company:	Policy number:	
Agent:	Policy Expires:	Deductibles:
Renters		
Company:	Policy number:	
Agent:	Policy Expires:	Deductibles:

Insurance

Health Insurance (supplement, Medigap, major medical, dental, long term care)		
Company:	Policy number:	
Agent:	Expiration Date:	
Deductibles or co-payments:		
Type of coverage:		
Company:	Policy number:	
Agent:	Expiration Date:	
Deductibles or co-payments:		
Type of coverage:		
Company:	Policy number:	
Agent:	Expiration Date:	
Deductibles or co-payments:		
Type of coverage:		
Company:	Policy number:	
Agent:	Expiration Date:	
Deductibles or co-payments:		
Type of coverage:		
Other Insurance: (professional, business, etc)		
Company:	Policy number:	
Agent:	Expiration date:	Deductibles:
Type of Insurance:		
Company:	Policy number:	
Agent:	Expiration date:	Deductibles:
Type of Insurance:		

Debt

Mortgages		
Owed to:	Original Amount:	Interest Rate:
Loan/Account number:	Monthly Payment:	Due Date:
Owed to:	Original Amount:	Interest Rate:
Loan/Account number:	Monthly Payment:	Due Date:
Home Equity Loans		
Owed to:	Original Amount:	Interest Rate:
Loan/Account number:	Monthly Payment:	Due Date:
Automobile Loans/Leases		
Owed to:	Original Amount:	Interest Rate:
Loan/Account number:	Monthly Payment:	Due Date:
Other Loans (secured, unsecured, margin, business, loans against cash value of insurance)		
Owed to:	Original Amount:	Interest Rate:
Loan/Account number:	Monthly Payment:	Due Date:
Owed to:	Original Amount:	Interest Rate:
Loan/Account number:	Monthly Payment:	Due Date:
Owed to:	Original Amount:	Interest Rate:
Loan/Account number:	Monthly Payment:	Due Date:
Credit Card Debt		
Issuer:	Account number:	Balance:
Issuer:	Account number:	Balance:
Issuer:	Account number:	Balance:
Issuer:	Account number:	Balance:
Issuer:	Account number:	Balance:

Available Monthly Income

<p>Salary:</p> <p>Partner's Income:</p> <p>Social Security:</p> <p>Pension/Keogh:</p> <p>Alimony:</p> <p>Interest Income:</p> <p>Dividends:</p> <p>IRA Distributions:</p> <p>Profit Sharing:</p> <p>Insurance Proceeds:</p> <p>Reverse Mortgage:</p> <p>Settlement Payments:</p> <p>Annuity Payments:</p> <p>Trust Distributions:</p> <p>Note or Loan Income:</p> <p>Cash from family members:</p> <p>Rental Income:</p> <p>Food Stamps:</p> <p>Welfare/SSI:</p> <p>Other:</p> <p>Other:</p> <p>Income Available at beginning of month:</p> <p>Cash on Hand:</p> <p>Checking Accounts:</p> <p>Savings Accounts:</p> <p>Money Market Accounts:</p> <p>Brokerage Accounts:</p> <p>Food Stamps on Hand:</p> <p>Other:</p> <p>Other:</p> <p>Total Income and Cash available for month:</p>		Date Received
--	--	----------------------

Monthly Expenses

	Monthly Amount	Date due
Rent or mortgage payment:		
Management/condo fees:		
Property/renters insurance:		
Home repairs and maintenance (including lawn care, snow removal, house cleaning, etc.):		
Telephone:		
Utilities (electricity, water, sewer, garbage, gas or oils):		
Cable/Satellite:		
Newspaper or other subscriptions:		
Other misc. household expenses:		
Average monthly cost of income taxes:		
Groceries:		
Dining out:		
Entertainment:		
Clothing:		
Laundry/dry cleaning:		
Contributions (church, clubs, etc.):		
Beautician/barber:		
Insurance premiums other than property and health:		
Other misc. expenses:		
Health insurance premiums:		
Health insurance deductibles or co- pays:		
Other health care cost (medications, equipment supplies, home care)		
Total Living Expenses:		

UTAH ADVANCE DIRECTIVE LAW

Mary Jane Ciccarello, JD
Henry & Ciccarello, LLC
1414 East 4500 South, Suite 2
Salt Lake City, Utah 84117
801-272-3511
mjc@elderlawutah.com

Utah's Advance Directives

- A. ***Living Will*** (Personal Choice and Living Will Act, Utah Probate Code, Section 75-2-1104)
- B. ***Special Power of Attorney for Health Care*** (Personal Choice and Living Will Act, Utah Probate Code, Section 75-2-1106)
- C. ***Medical Treatment Plan*** (Personal Choice and Living Will Act, Utah Probate Code, Section 75-2-1105)
- D. ***EMS/DNR*** (Personal Choice and Living Will Act, Utah Probate Code, Section 75-2-1105.5 and Utah Administrative Code R426-100)
- E. ***POLST or the Transferable Physician Order for Life-Sustaining Treatment*** (Utah Administrative Code R432-31)
- F. ***Declaration for Mental Health Treatment Form*** (Utah Code, Section 62A-15-1104)
- G. ***Uniform Anatomical Gift Act*** (Utah Code, Sections 26-28-2 to 26-28-12)

A. Living Will

- *Who can make one?* Competent adult.
- *Is there a form?* Yes, Utah law requires a living will to follow substantially the form in the Personal Choice and Living Will Act.
- *What does the form require?* The person completing the living will must complete the form, date and sign it before two witnesses, and the two witnesses must sign it. The witnesses cannot be related by blood or marriage to the person, cannot be providing health care to the person, and cannot be an heir of the person.
- *Can the form be changed, amended, or revoked?* Yes, at any time the person is capable of doing so. An oral revocation is sufficient if the person is currently capable of giving medical directions to health care providers.
- *Where should the form be kept?* The person should keep the original in a safe but accessible place. Copies should be given to health care facilities upon admission, to attending physicians, and to trusted friends and relatives.
- *When does the form go into effect?* Upon written certification by two physicians who have physically examined the person and found the person to be either in a persistent vegetative state or in a terminal condition.
- *Can anyone override a valid living will?* Yes. An agent appointed under a special power of attorney for health care has the legal authority to override any previously executed advance directive. While not entirely clear under Utah law, a guardian who has the authority to make health care decisions can most likely legally override a valid living will. However, so long as the person is capable of giving current directions to health care providers, then the wishes of that person must be followed.
- *Is a living will made in another state valid in Utah?* Yes.

B. Special Power of-Attorney for Health Care

- *Who can make one?* Competent adult.
- *Is there a form?* Yes, Utah law requires a special power of attorney to follow substantially the form in the Personal Choice and Living Will Act.
- *What does the form require?* The person completing the special power of attorney must complete the form, designate an agent, and date and sign it before a notary public. No witnesses are required.
- *Can the form be changed, amended, or revoked?* Yes, at any time the person is capable of doing so. An oral revocation is sufficient if the person is currently capable of giving medical directions to health care providers.

- *Where should the form be kept?* The person should keep the original in a safe but accessible place. Copies should be given to health care facilities upon admission, to attending physicians, and to the appointed agent.
- *When does the form go into effect?* When health care providers, usually the attending physician, determines that the person is no longer capable of giving current directions regarding medical treatment.
- *Can anyone override a valid special power of attorney?* Probably not. Under Utah law, an appointed agent has first priority as a proxy health care decision maker. However, so long as the person is capable of giving current directions to health care providers, then the wishes of that person must be followed.
- *Is a health care power of attorney made in another state valid in Utah?* Yes.

C. Medical Treatment Plan

- *Who can make one?* Competent adult or legal proxy and attending physician.
- *Is there a form?* Yes, Utah law requires a medical treatment plan to follow substantially the form in the Personal Choice and Living Will Act.
- *What does the form require?* The person completing the medical treatment plan must complete the form, date and sign it before two witnesses, and the two witnesses must sign it. The witnesses cannot be related by blood or marriage to the person, cannot be providing health care to the person, and cannot be an heir of the person. In addition, the treating physician must complete the form by indicating the treatment plan agreed upon and signing and dating it. If the person is not capable, according to the physician, of giving current medical directions, then the person's proxy may complete the plan together with the attending physician. Utah law recognizes the following as legal proxy decision makers in the following order:
 - An attorney in fact;
 - Any previously appointed legal guardian of the declarant;
 - The person's spouse if not legally separated;
 - The parents of surviving parent;
 - The person's child 18 years of age or older, or if the person has more than one child, by a majority of the children 18 years of age or older who are reasonably available for consultation upon good faith efforts to secure participation of all those children;
 - By the declarant's nearest reasonably available living relative 18 years of age or older if the declarant has no parent or child living;
 - By a legal guardian appointed for the purposes of this section.

- *Can the form be changed, amended, or revoked?* Yes, at any time the person or proxy, in conjunction with the treating physician, is capable of doing so. An oral revocation is sufficient if the person is currently capable of giving medical directions to health care providers.
- *Where should the form be kept?* The completed medical treatment plan is usually kept in the person's medical files.
- *When does the form go into effect?* Upon completion.
- *Can anyone override or change a medical treatment plan?* Yes. An agent appointed under a special power of attorney for health care has the legal authority to override any previously executed advance directive. According to the proxy statute, any listed proxy with priority would have the legal authority to complete a current medical treatment plan for the person. However, so long as the person is capable of giving current directions to health care providers, then the wishes of that person must be followed.
- *Is a medical treatment plan made in another state valid in Utah?* Probably not. The medical treatment plan is a specific Utah advance directive.

D. EMS/DNR

- *Who can make one?* Competent adult or legal proxy and attending physician.
- *Is there a form?* Yes. The form must come from the Utah Department of Health through the person's physician.
- *What does the form require?* The person's physician must complete the form issued by the Utah Department of Health. Each EMS/DNR form must have a state of Utah watermark and a unique identifying number provided by the Department of Health. The physician must make the determination that the person is in a terminal condition and then complete the form with the person or the person's legal proxy. The physician must sign and date the form and give the original to the person or the person's proxy. The physician should also complete the authorized EMS/DNR bracelet or necklace and give it to the person or the person's proxy. The physician must then confirm with the Department of Health that the EMS/DNR has been completed and the bracelet or necklace placed with the person and then submit a duplicate original of the form to the Department of Health. If the person is not capable, according to the physician, of giving current medical directions, then the person's proxy may complete the form together with the attending physician. Utah law recognizes the following as legal proxy decision makers in the following order:

- An attorney in fact;
 - Any previously appointed legal guardian of the declarant;
 - The person's spouse if not legally separated;
 - The parents of surviving parent;
 - The person's child 18 years of age or older, or If the person has more than one child, by a majority of the children 18 years of age or older who are reasonably available for consultation upon good faith efforts to secure participation of all those children;
 - By the declarant's nearest reasonably available living relative 18 years of age or older if the declarant has no parent or child living;
 - By a legal guardian appointed for the purposes of this section.
-
- *Can the form be changed, amended, or revoked?* Yes. If there is any question about the validity of an EMS/DNR form, the EMS personnel must provide emergency medical services to the person as if no EMS/DNR form had been issued.
 - *Where should the form be kept?* The completed form must be sent to the Department of Health. The EMS/DNR is the property of the person and shall be kept with the person's medical record, but is not part of the medical record. To be honored by EMS personnel, the EMS/DNR form must be placed in an unobstructed view above the person on the wall or in close proximity to the head of the bed or the person must be wearing the bracelet or necklace, except in licensed health care facilities.
 - *When does the form go into effect?* Upon completion.
 - *Can anyone override or change a medical treatment plan?* Yes. An agent appointed under a special power of attorney for health care has the legal authority to override any previously executed advance directive.
 - *Is an EMS/DNR made in another state valid in Utah?* No. The EMS/DNR is a specific Utah form promulgated by the Utah Department of Health.
 - *Special Update:* As of March 2003, the Administrative Code rule that regulates the *EMS/DNR* has been amended to allow for EMS personnel to honor and comply with the Transferable Physician Order for Life Sustaining Treatment Forms (POLST), including a physician order not to resuscitate a patient that does not meet the formalities on the *EMS/DNR* form.

E. POLST

- *Who can make one?* Competent adult or legal proxy and attending physician.
- *Is there a form?* Yes. The form must come from the Utah Department of Health either through the person's physician or a licensed health care facility.

- *What does the form require?* The person's physician must complete the form issued by the Utah Department of Health together with the person or the person's legal proxy. The purpose of the form is to provide for the orderly communication and transfer of patient preferences for life sustaining treatment when a patient transfers from one licensed health care facility to another.
- *Can the form be changed, amended, or revoked?* Yes.
- *Where should the form be kept?* The completed form is part of the person's medical record and should be kept in the medical file or with the person.
- *When does the form go into effect?* Upon completion.
- *Can anyone override or change a medical treatment plan?* Yes. An agent appointed under a special power of attorney for health care has the legal authority to override any previously executed advance directive.
- *Is a POLST form made in another state valid in Utah?* No. The POLST form is a specific Utah form promulgated by the Utah Department of Health.

Checklist

Checklist to help you make the most of Healthcare Encounters

Doctor's Office visit checklist

Before the visit

Gather your questions	Identify current symptoms	Check the patient file
Call to confirm appointment	Record doctor's instructions	
Discuss recommendations	Verify follow-up	

During the visit

Help with reporting	Describe symptoms accurately	Ask questions
---------------------	------------------------------	---------------

After the visit

Review your notes	Check prescriptions	Discuss the visit
Update your calendar	Call for test results	

Emergency Room Checklist

Being prepared

- Post emergency information in a prominent place
- Have updated patient information ready to go
- Enlist a friend to be your "ER buddy" before a crisis occurs
- Pack a bag ahead of time

At the emergency room

- Relay critical information to the ER staff
- Introduce yourself to the head nurse and attending physician
- Get out of the way wait patiently
- Review patients' rights information while waiting
- Ask for regular updates
- Gauge your loved one's reactions
- Listen and ask questions
- Recognize staff limitations
- Stay calm and take care of yourself

Checklist to help you make the most of Healthcare Encounters

Doctor's Office visit checklist

Before the visit

Gather your questions	Identify current symptoms	Check the patient file
Call to confirm appointment	Record doctor's instructions	
Discuss recommendations	Verify follow-up	

During the visit

Help with reporting	Describe symptoms accurately	Ask questions
---------------------	------------------------------	---------------

After the visit

Review your notes	Check prescriptions	Discuss the visit
Update your calendar	Call for test results	

Emergency Room Checklist

Being prepared

- Post emergency information in a prominent place
- Have updated patient information ready to go
- Enlist a friend to be your "ER buddy" before a crisis occurs
- Pack a bag ahead of time

At the emergency room

- Relay critical information to the ER staff
- Introduce yourself to the head nurse and attending physician
- Get out of the way wait patiently
- Review patients' rights information while waiting
- Ask for regular updates
- Gauge your loved one's reactions
- Listen and ask questions
- Recognize staff limitations
- Stay calm and take care of yourself

Checklist

Checklist to help you make the most of Healthcare Encounters

Doctor's Office visit checklist

Before the visit

Gather your questions	Identify current symptoms	Check the patient file
Call to confirm appointment	Record doctor's instructions	
Discuss recommendations	Verify follow-up	

During the visit

Help with reporting	Describe symptoms accurately	Ask questions
---------------------	------------------------------	---------------

After the visit

Review your notes	Check prescriptions	Discuss the visit
Update your calendar	Call for test results	

Emergency Room Checklist

Being prepared

- Post emergency information in a prominent place
- Have updated patient information ready to go
- Enlist a friend to be your "ER buddy" before a crisis occurs
- Pack a bag ahead of time

At the emergency room

- Relay critical information to the ER staff
- Introduce yourself to the head nurse and attending physician
- Get out of the way wait patiently
- Review patients' rights information while waiting
- Ask for regular updates
- Gauge your loved one's reactions
- Listen and ask questions
- Recognize staff limitations
- Stay calm and take care of yourself

The Doctor's Office

Preparing for the appointment:

- Be prepared to briefly explain the patient's and the family's medical history
 - This will be particularly important for the initial visit.
- Prepare a list of questions.
 - Put in order of importance/
 - Use a notebook/journal to record questions between Dr.'s visits.
- Identify current and/or new symptoms.
 - Use a notebook/journal to record health changes.
 - Refer to the Symptom Reporting Form.
- Check the personal medical records
 - Try to maintain some type of personal medical/health record.
- Be prepared to take notes or ask for written information on the medical situation, change in medications etc.
- Call to confirm the appointment

During the medical appointment:

- Assist the care-receiver with reporting
 - Let them take the lead as you help fill in gaps and gently correct inaccuracies
- Describe symptoms accurately
 - Refer to the Symptom Reporting Guide
 - Start with the most significant changes or symptoms
- Ask questions
 - Go through the list of questions you prepared & write down the answers
 - If something is not clear ask for clarification
- Record doctor's instructions re: treatments, home care, medications, etc.
 - If doctor suggest something you know you or the care recipient cannot do or manage ask for another treatment plan and explain why.
- Discuss recommendations
 - Make sure you understand the reasons and expected results
 - Investigate options for invasive procedures
 - Ask why tests or treatments are needed and what the risks are
 - Consider all options, including the pros and cons
- Verify any follow up
 - Find out when test results will be available
 - When next appointment needs to be scheduled

After the medical appointment

- Review your notes
 - Call office for clarification if needed
- F/u on any prescriptions
 - Fill new prescriptions immediately & make sure filled correctly
- Review the visit
 - Discuss how visit went
 - Go over any new treatments or changes in treatment
- Updated your calendar
 - Put date of next visit or any f/u procedures
- Call for test results

How does the Doctor's Office Function?

In order to make the best use of your time and physician it is important to learn as much as you can regarding each of the medical practices you work with. Each office will have it's own unique way of running things based upon the personalities and beliefs of the physicians and staff who work there. The following are a list of things to find out as you are working with your physician(s).

What are the regular office hours and days of operation?

When is the best time to reach the doctor?

Does he have certain times he takes/returns calls?

Is he best reached by phone, by fax, e-mail?

Who is on-call for him or able to answer questions when he is unavailable?

Who can best answer your questions regarding:

Making an appointment

Answering general medical questions

Looking up information in the patient chart

Providing test results

Confirm correct medications and dosages

Help arrange for prescription refill, etc.

Help with medical emergencies

Insurance or billing questions

How are after hour care and medical emergencies handled?

Who should you call after hours or when the doctor is unavailable?

How should you handle a medical emergency?

Which emergency or urgent care facility does the doctor prefer you use?

At which hospitals and specialty clinics does the doctor have practice privileges?

Questions to ask about insurance and billing

Does the office accept your insurance?

Who is responsible for filing insurance claims?

What are the charges for typical services, such as regular office visits?

What forms of payment does the office accept?

If on Medicaid and/or Medicare does the office accept those as full payment for care?

What forms need to be completed and signed so they can provide treatment, bill insurance?

Question Guide for Medical Care

General medical care questions:

- What is the medical term for the illness? What may be the cause of the illness?
- Will this illness require treatment or will it likely go away on its own?
- What can be expected regarding the amount of pain? Is it likely to increase or decrease?
- What are your recommendations on how to best treat this illness?
- Are there other options for treating this illness?
- What risks are associated with the different treatments?
- What are the likely outcomes with the recommended treatment? Without the recommended treatment?
- What is the regimen for the treatment and how long will it last.
- Will treatment require hospitalization?
- What is the expected recovery time?
- Will there be any lifestyle changes?

Questions regarding medical tests or procedures

- What is the test procedure?
- Why is the test needed? Is it necessary to confirm or disprove a diagnosis?
- Will the findings affect the way the illness/disease will be managed? If the test is positive, what course of action is indicated?
- What risks are involved? Do the benefits outweigh the risks?
- What could be the outcome be if my care receiver refuses to undergo the test?
- How accurate is the test? What are the chances of an inaccurate test result?
- What are the costs associated with test? Is there a less expensive test? Will my insurance cover the cost?
- What will the test feel like? Is it painful? Will it require sedation?
- What steps need to be taken to prepare for the test? Are x-rays necessary?
- Will the patient need help getting home afterward?
- Will the test require a change in any of the medications?
- Who will interpret the test results?
- Will someone call with the results or do we need to phone in for them?
- Can the test results be sent directly to me or my care recipient?
- Will the doctor review the test report with us and explain the details?

Questions regarding surgery

- Why does the patient need the surgery?
- Will it stop the disease or merely slow its progress?
- What are the alternatives? Including, non-invasive procedures?
- Will the patient need to be hospitalized? Can it be done on an outpatient basis?
- What are the potential outcomes if the surgery is not done?
- Where will the surgery be done? When?
- What can be expected regarding treatment and recovery after the surgery?
- Is there a less expensive hospital or surgical center?
- Will there be a consultation with the surgeon before the surgery? Will the surgeon being interviewed do surgery or will he delegate it to a junior associate?
- How many surgeries of this type has the surgeon performed? What has been the success rate?
- Who will be the anesthesiologist and what are his qualifications?
- What are the potential risks? Does the potential benefit outweigh the risks?
- How much will it cost and will my insurance cover the cost?
- What other specialists can I ask for a second opinion?

Question Guide for Medical Care

Questions regarding Medications:

Questions to ask the Doctor

Make sure that the doctor has an accurate list of all medications; including eye drops, vitamins and other over the counter medications.

Make sure the doctor know what other treatments and therapies the person is on.

Make sure the doctor is aware of any allergies or food sensitivities

Understand why each Medication is needed and how much it will help the person's condition

Ask if it is possible to relieve pain almost completely, then seek the medicine that is most effective

Ask how long the drug takes to work

Find out potential side effects and possible interactions with other medications

Discuss if there are other approaches, such as diet, exercise, stress reduction, etc)

For a confused elderly person, ask for medicines that can be taken easily.

If there are several medications that need to be taken, ask the doctor to prescribe them so they can be taken at the same times each day. If a drug must be taken at a difficult time, see if another choice is available.

Ask if a generic drug or another brand within the same drug class is available to try to find the lowest cost alternative. Check to see what brand your insurance will cover?

Ask if a lower dose can be prescribed without adverse effects?

To keep costs down, ask if a higher dose can be safely prescribed and the pill cut in half? Ask if you can buy just a one-week supply of a new medication until you know if the patient can tolerate any possible side effects.

Questions to Ask the Pharmacist

Shop around for the least expensive pharmacist, than stay with it.

For Medicare patients, ask about the government's maximum allowable charge for a particular drug.

Ask what over-the-counter drugs the pharmacist recommends for the person's condition.

Ask if your insurance will pay for the drug the doctor has ordered. If not, ask if about alternatives that the doctor could prescribe.

Ask about generic substitutes for the prescription drug. Find out what about any adverse side effects of the generic substitute.

Ask if the multiple drugs prescribed can cause potential toxic drug interactions. Does the pharmacist have a computer system that will alert him about potential drug interaction side effects before the prescription is filled?

Find out the risks of not taking and/or finishing the prescription.

For someone taking multiple prescriptions, seek out a pharmacy that will do simplified packaging.

Ask if the medicine can be put in an easy-to-open, large size container with a label in large print.

Ask if an overdose of the medicine is dangerous for children or a confused elderly person. Ask what effects smoking and/or drinking alcohol if taken while on this medication.

Ask if the person can drive while on this medicine

Ask if the medicine must be taken with a meal, with water or milk, etc.

If the person needs many expensive drugs, find out about discounts or payment plans.

Obtaining Recommendations

Obtaining Recommendations

- It is not wise to just open the yellow pages and pick a doctor
- Ask friends, relatives, and trusted colleagues at work
- Ask your bishop, pastor, rabbi or spiritual advisor
- Check with nurses, social workers, psychologists, dentists or other health care professionals you know
- Talk with other family caregivers who are caring for someone with a similar condition
- Call a local member of a national or regional support group that relates to your loved one's medical condition
- Check with your state and county medical associations and any regional medical schools
- Find out if there is a physician referral service
- Talk with a community resource center

Selecting a new Doctor

Check credentials, contact state medical licensing board

Call the office

- Check to see if they are accepting new patients

Follow up on Office Services and procedures

- Speak with the office manager
- Find out if they accept your medical insurance
- Find out what hospitals and clinics they are affiliated with
- Find out more about how their office operates

Make an Appointment

- Set up a new patient preliminary consultation

Check the environment

- Notice the surroundings, talk with receptionist and staff
- Observe how they treat people
- Observe how the appearance of the office. Does it appear to be neat and well-run?
- What type of feeling did you have when you walked in?

Meet the Doctor

- Discuss patient's current medical status and reason why you are changing physicians
- Pay attention to quality of communication skills
- Ask questions until you feel satisfied that he has the expertise and understand needs of the patient

Assess the Visit

- How does your loved on feel about the doctor?
- Did you feel the doctor answered your questions openly and in ways that you could easily understand?
- Did the doctor instill a sense of trust and treat you respectfully?
- Did you sense that the doctor understood and respect the care recipient's opinions and beliefs?
- Did you feel the doctor had a good understanding and knew what he was talking about?
- Do you feel you can work with and relay on this Doctor?

After you find a new doctor

- Make sure you get him "up to speed" on your care recipient's case as quickly as possible.
- Re-assure the person you are caring for.
- Ask for a more in-depth consultation appointment.
- F/u with the medical records staff in both the old and new physicians office to make sure that records get transferred properly.

Emergency Room Visit

Being Prepared

Post Emergency information in a prominent area

- Care receivers primary care physician
- Local rapid-response number or ambulance company
- Number of local hospital Emergency Room
- Name of Family/Friend to call assist in event of Emergency
- Poison Prevention Hotline Number

Have patient's medical records and information easily accessible

Find a trusted family member or Friend who can easily and readily assist you in an emergency

Prepare an Emergency Bag

- If there is a history of frequent ER visits, pack a small overnight bag with a few toiletries, nightgown or pajamas, set of underwear.
- Place this bag where it is easily accessible and close to patient's medical records.
- You may also want to add to the bag a few necessities of your own in case you want/need to stay overnight with the patient.

At the Emergency Room

Provide Critical Information

- Describe as completely and simply the patient's condition and crisis symptoms

Identify yourself as the caregiver

- Find out names of the nursing staff and physician assigned to the care recipient.
- If you feel you need some additional support, ask for the Social Worker on call

Keep out of the way

- Provide the space and room for the ER personnel to do their job
- This does not mean that you have to leave the ER or the patient's room; however, there may be times that you will be asked to go to the waiting room.

Be patient

- Wait in a nearby-designated family waiting area.
- If the ER staff need to speak with you, they will expect to find you in the designated waiting room.
- If you need to leave the area for more than five minutes, let someone know where you will be and how to reach you if needed.

Be familiar with Patient's Rights

- Take time to learn about or review the legal rights and responsibilities
- "A Patient's Bill of Rights" should be posted on each hospital floor.

Ask for Updates

- It is appropriate to ask for a status report about every 30-45 minutes.

Listen and Clarify

- Find out how your loved one feels and what their concerns are; relay relevant information to the ER Staff
- Take notes and ask questions until you clearly understand
- Recognize Staff Limitations; be considerate and kind.
- Stay Calm, breathe deeply, and speak slowly and clearly.
- **On the way out thank those who have provided care to your loved one.**

Hospital Care

In the Hospital

Provide Information

- Have client's medical information and records available

Identify yourself as the caregiver

- Find out names of the staff providing care for your loved one.
- Identify yourself as the caregiver and your role in assisting the patient with their medical care and decision making.
- Only agree to procedures that make sense
- If you think a procedure is needed, ask why it is not being provided

Be patient, considerate and helpful

- Be friendly and respectful, use a positive approach
- Recognize staff limitations.
- Be considerate of staff needs when certain procedures or tests need to be completed.
- Make sure staff understand where and how to reach you when you are not at the hospital or if you are going to leave the room for a few minutes.
- Assist with grooming and care

Be familiar with Patient's Rights

- Take time to learn about or review the legal rights and responsibilities
- "A Patient's Bill of Rights" should be posted on each hospital floor. If not ask for a copy.

Listen, ask questions, and clarify

- Be an advocate for the wishes of your loved on regarding their care
- Only agree to procedures that make sense. If you think a procedure is needed as why it is not being provided.
- Take notes and ask questions until you clearly understand
- Recognize Staff Limitations, be considerate and kind.
- Check itemized bills and ask questions about unclear portions.

Discharge Planning

Goals of Discharge planning

- Make sure the person is being discharged to the appropriate setting
- Ensure that the client has the needed supports and they are set up prior to discharge
- Feel comfortable, capable and confident with what is expected of you after the person is discharged.

Role of the family Caregiver

- Identify yourself
 - Make sure discharge planner knows who you are and your role in making health care decisions for this person.
 - Make sure you are a partner in the health care team
- Meet with the Discharge planner
 - This individual is the key resource for helping to identify needs, set up services and resolve discharge planning issues
- Identify Care Issues
 - Discuss what care and services were available prior to the hospitalization
 - Identify new care needs
 - Discuss what role you played in the person's care before the hospitalization
 - Identify and discuss how your role will change
 - Discuss limitations with regards to what you will be able to provide

The Discharge Process

- May vary some among hospitals
- In general, the doctor will prepare discharge orders
- These will be reviewed with the patient and caregiver
- The discharge orders will need to be signed

Hospital Care

Questions to ask regarding Discharge

- Where is the patient going after discharge?
 - Will this be a permanent or temporary placement for rehabilitation?
 - If going to facility for rehab. How long can expect them to be there?
- Who will provide additional home health care if it is needed
 - What type of home health care will be needed
 - Bathing and personal care
 - Physical, occupational, speech Therapy
 - Skilled nursing care
 - Ask for list of Home Health providers in your area
 - Make sure you are given a choice of available providers to choose from
 - Discuss how long they think that home health will be needed
 - Discuss what options are available for in-home services once client is no longer eligible for Medicare Services.
- Will there be any home health equipment needed?
 - What Kind?
 - Is it covered by Medicare, Medicaid, Insurance
 - If not, are their other resources available to help with the cost.
- What additional services may be needed and for how long?
 - Meals on Wheels
 - Hospice care
 - Housekeeping
 - Other in-home services (i.e. companion, transportation, shopping, ERS)
- What paperwork needs to be processed to set up needed services?
- How will the added expenses be paid for
 - Will insurance pay for it
 - Will it have to be private paid
 - Are the Home and Community based programs available to assist
- What additional skills do I need to learn in order to properly care for and meet the needs of my loved ones?

Checklist for Coming home from the Hospital

- Assess the person's condition and needs.
- Understand the diagnosis and prognosis.
- Become part of the care team
- Get complete written instructions
- Arrange follow-up care from the doctor
- Develop a plan of care with doctor, discharge planner
- Meet with discharge planner to determine home care benefits
- Understand in-home assistance options
- Arrange for in-home help
- Arrange for physical, occupational, and speech therapy as needed
- Find out what medicines patient will be discharged with and what ones need to be filled. Prepare the home
- Arrange for needed supplies and equipment
- Take home all personal items.
- Check with billing office for discharge payment requirements
- Arrange transportation